**U.S. Department of Labor**

Office of Administrative Law Judges
Seven Parkway Center - Room 290
Pittsburgh, PA 15220

(412) 644-5754
(412) 644-5005 (FAX)

**Issue Date: 11 December 2003**

Case No.: 2001-BLA 1008

In the Matter of:

CATHERINE D. BARTLEY Survivor of ARNOLD BARTLEY,
Claimant

v.

UNION CARBIDE CORPORATION,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Roger D. Forman, Esquire,
*For the Claimant*

Kathy L. Snyder, Esquire,
*For the Employer*

Before: Robert J. Lesnick
Administrative Law Judge

## DECISION AND ORDER – AWARDING BENEFITS

This case arises from a claim for benefits under the "Black Lung Benefits Act," Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. §901 *et seq.* (hereinafter referred to as "the Act"), and applicable federal regulations, mainly 20 C.F.R. Parts 718 and 725 ("Regulations"). [1]

[1] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The amended Part 718 regulations became effective on January 19, 2001 and were to apply to both pending and newly filed cases. The new Part 725 regulations also became effective on January 19, 2001. Some of the new procedural aspects of the Part 725 regulations, however, were to apply only to claims filed on or after January 19,

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as black lung.[2]

A formal hearing was scheduled for April 15, 2003 in Charleston, West Virginia. On April 2, 2003, counsel for Claimant advised she would not be attending the hearing and requested a decision on the record. Counsel for Employer had no objection and on April 11, 2003, I issued an Order Granting Decision on the Record. In that Order I also allowed the deposition of Dr. Wheeler scheduled for April 30, 2003, to take place.[3] On June 19, 2003, Claimant filed her closing brief and on July 1, 2003, Employer filed its closing brief.

## ISSUES

The contested issues are:

1. Whether the miner had pneumoconiosis or complicated pneumoconiosis?
2. Whether the pneumoconiosis arose out of the miner's coal mine employment?
3. Whether the miner's death was due to pneumoconiosis?

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2001, *not* to pending cases. The Amendments to the Part 718 and 725 regulations were challenged in a lawsuit filed in the United States District Court for the District of Columbia in *National Mining Association v. Chao*, No. 1:00CV03086 (EGS). On February 9, 2001, the District Court issued a Preliminary Injunction Order that enjoined the application of the Amendments "except where the adjudicator, after briefing by the parties to the pending claim, determines that the regulations at issue in the instant lawsuit will not effect the outcome of the case." On August 9, 2001, the United States District Court for the District of Columbia issued a decision granting the U.S. Department of Labor's motion for summary judgment in *National Mining Association v. Chao*, dissolved the preliminary injunction, and upheld the validity of the amended regulations. The case was subsequently appealed and on June 14, 2002, the United States Court of Appeals for the District of Columbia Circuit issued a decision that affirmed in part, reversed in part and remanded the case back to the District Court for further instruction. The Court of Appeals upheld the validity, for the most part, of the challenged amendments except that the Court found the following sections to be impermissibly retroactive: §§718.204(a), 725.701, 725.101(a)(31), 725.204, 725.212(b), 725.213(c), 725.214(d), 725.219(c) and (d). The Court also found §725.101(a)(6) to be invalid.

[2] The following abbreviations have been used in this opinion: DX = Director's exhibit, EX = Employer's exhibit, CX = Claimant's exhibit, TR = Transcript of the hearing, BCR = Board-certified radiologist, BCI = Board-certified internist, and B = B reader.

[3] Director's exhibits 1 through 25 and Employer's exhibits 1 through 6 are hereby admitted into evidence without objection.

## FINDINGS OF FACT

### Procedural History and Factual Background[4]

The miner, Arnold Bartley, filed his claim for Black Lung benefits on February 14, 1983. (DX 23-1). On May 14, 1984, the District Director issued an award of benefits. (DX 23-12). On May 24, 1984, Employer agreed to pay benefits in this matter. (DX 23-16). On June 13, 1984, the District Director issued an Award of Benefits. The District Director found the miner had 30 years of coal mine employment, from July 13, 1948 to July 25, 1980. (DX 23-18).

The miner died on August 20, 2000. (DX 4). Claimant, Catherine D. Bartley, filed her application for survivor's benefits on September 28, 2000. (DX 1). On June 5, 2001, the District Director issued a Notice of Initial Determination awarding survivor's benefits to Claimant. (DX 20). The District Director found there was sufficient evidence of complicated pneumoconiosis and that the presumption at §718.304 was applicable. Employer disagreed with the findings and requested a formal hearing. (DX 21). As noted previously, at the request of Claimant, I issued an Order Granting Decision on the Record.

### Medical Evidence

Chest X-rays[5]

| X-ray | Exhibit | Physician/Qualifications | Interpretation |
|---|---|---|---|
| 11-30-81 | DX 23-20 | R.O. Gale/ BCR, B | 1/0, p |
| 6-30-83 | DX 23-1 | Sargent/ BCR, B | 2/2, u/t, 6 zones, size C |

[4] Given the filing date of this claim, subsequent to the effective date of the permanent criteria of Part 718, (i.e. March 31, 1980), the Regulations set forth at 20 C.F.R. Part 718 will govern its adjudication. Because the miner's last exposure to coal mine dust occurred in West Virginia, this claim arises within the territorial jurisdiction of the United States Court of Appeals for the Fourth Circuit. *See Broyles v. Director, OWCP*, 143 F.3d 1348, 21 BLR 2-369 (10th Cir. 1998).

[5] A=A-reader; B=B-reader; BCR=Board-Certified Radiologist; R=Radiologist; BCP=Board-Certified Pulmonologist; BCI=Board-Certified Internal Medicine; BCCC=Board-Certified Critical Care. Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. B-readers need not be radiologists. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b).

| | | | |
|---|---|---|---|
| 6-30-83 | DX 23-9 | Gaziano/ B | 1/2, r/s, 6 zones, size B |
| 4-26-00 | DX 5,7,10 | Soong | Marked fibrosis w/egg-shell calcifications, large conglomerate masses may be related to progressive massive fibrosis or may be tumor process or acute or interval change; without benefit of old films, overall appearances may represent CWP and PMF |
| 4-26-00 | DX 11 | Sargent/ BCR, B | 1/0, s/p, 6 zones, size C |
| 4-26-00 | EX 1 | Wheeler/ BCR, B | Negative for CWP; Few 2 cm masses right mid-lung, 2-3 cm masses left mid-lung, compatible w/ conglomerate<br>TB more likely than large opacities of CWP b/c no background nodular infiltrates; moderate em |
| 4-26-00 | EX 1 | Scott/ BCR, B | Negative for CWP; 5 x 8 cm masses both upper lungs, probable granulomatous masses due to TB, few smaller masses probably due to TB, unknown activity; no background of small rounded opacities to suggest silicosis |
| 4-26-00 | EX 3 | Kim/ BCR, B | Negative for CWP; well-defined masses both upper lobes, largest diameter 8 cm, bullous emphysema, overall changes probably represent granulomatous process than silicosis due to lack of nodules in background |
| 6-28-00 | DX 13, 14 | Sargent/ BCR, B | 2/2, p/s, 6 zones, size C |
| 6-28-00 | EX 1 | Wheeler/ BCR, B | Negative for CWP; masses in |

| | | | |
|---|---|---|---|
| | | | both lungs compatible w/TB or histoplasmosis w/calcified granulomata from healed TB or histoplasmosis; moderate COPD; large opacities of CWP unlikely w/o background nodular infiltrate but check to see if driller w/no respiratory protection |
| 6-28-00 | EX 1 | Scott/ BCR, B | Negative for CWP; 5 x 8 cm masses, bilaterally; probably granulomatous masses due to TB; bullous em; no background small rounded opacities to suggest silicosis |
| 6-28-00 | EX 3 | Kim/ BCR, B | Negative for CWP; bilateral upper lobe masses, 8 cm largest diameter, no background nodules, suggestive of granulomatous process |
| 6-29-00 CT | EX 1 | Wheeler/ BCR, B | 7 x 4 cm mass left UL, 6 cm mass in RUL, both contain calcified granulomata compatible w/conglomerate TB or histoplasmosis; ring calcifications seen in histoplasmosis, CWP and silicosis, and granulomatous disease; COPD and linear interstitial fibrosis; miner old enough to have had unprotected drilling exposure which could cause large opacities of CWP; no background nodules; rarely all small nodules merge in to large opacities so correlation w/past exposure needed |
| 6-29-00 CT | EX 1 | Scott/ BCR, B | 5 cm masses both upper lungs; probably granulo-matous masses due to TB; no |

| | | | |
|---|---|---|---|
| | | | significant background of small rounded opacities making it unlikely due to silicosis; eggshell calcific-ations; bullous em |
| 6-29-00 CT | EX 3 | Kim/ BCR, B | 5-6 cm masses both upper lungs w/several small calcifications, probable granulomatous process; no nodular background to suggest silicosis, eggshell type calcifications, bullous em |

Occupational Pneumoconiosis Board

On October 30, 1980, the Occupational Pneumoconiosis Board awarded the miner a 20% permanent total disability due to occupational pneumoconiosis. The award was due, in part, to x-ray studies dated October 29, 1980, that revealed multiple bilateral conglomerations in association with areas of tiny rounded and fine irregular type nodular fibrosis. (DX 23-5).

On June 25, 1985, the Occupational Pneumoconiosis Board awarded a 30% permanent total disability due to occupational pneumoconiosis, representing an additional 10% than previously found. (DX 23-5). The Board noted that the chest x-rays showed generalized emphysema and large conglomerate masses as well as pleural thickening and large rounded irregular type areas of nodular fibrosis in a somewhat extensive amount. It was noted that the conglomerate masses had increased in size considerably since 1980. Film studies from June 24, 1985, January13, 1983, April 24, 1970, and October 29, 1980 were reviewed and considered.

Pulmonary Function Studies

| **Ex No.** | **Date** | **Age** | **Height** | **FEV1** | **MVV** | **FVC** | **Qualify** |
|---|---|---|---|---|---|---|---|
| DX 23 | 6-30-83 | 54 | 70 ¼” | 2.55 | 86 | 3.90 | No |
| | | | | 2.73* | 105* | 3.96* | No |

*Post-bronchodilator

Arterial Blood Gas Studies

| **Exhibit No.** | **Date** | **PO2** | **PCO2** | **Qualify** |
|---|---|---|---|---|
| DX 23 | 6-30-83 | 82 | 34 | No |

Miscellaneous Medical Records and Reports

Dr. D. Gaziano

Dr. Gaziano's medical report is dated July 7, 1983, and appears at DX 23-8. Dr. Gaziano examined the miner at the request of the Department of Labor on June 30, 1983. Dr. Gaziano reviewed the miner's occupational history and noted a family history positive for heart disease and diabetes. The miner had a positive medical history for arthritis, heart disease, and heart catheterization in 1980. The miner smoked ½ pack of cigarettes for 25 years, one pack per day for 11 years and less than ½ pack per day for 3 years. The miner's chief complaints were productive cough, dyspnea, and chest pain. Physical examination was unremarkable. Dr. Gaziano diagnosed the miner as having complicated pneumoconiosis due to his coal mine employment.

Medical Records of Dr. Michael Dillon

The medical records of Dr. Dillon appear at DX 9. Dr. Dillon was a cardiologist in Gainesville, Florida, who treated the miner for his cardiac symptoms. He first evaluated the miner in April 1991. In a letter addressed to Dr. Prudencio, dated April 5, 1991, Dr. Dillon noted that the miner's major problem related to coal workers' pneumoconiosis and that he had significant scarring as a result of the CWP. He noted that at one time this may have represented lung cancer but that a lung biopsy revealed fibrosis and scarring only. He noted that the chest x-ray showed extensive scarring and plaquing, presumably from working in a coal mine. The miner subsequently was examined by Dr. Dillon for evaluation of his heart condition on a yearly basis from 1991 through 2000. In his April 1994 report, Dr. Dillon noted that the miner had coughing episodes that left him feeling light-headed. Dr. Dillon further noted that this suggested some underlying chronic lung disease. In his April 1995 report, Dr. Dillon noted the miner complained of shortness of breath, which he then attributed to the miner's underlying lung disease.

Medical Records of Dr. Keith M. Justice

Dr. Justice did two consultations for evaluation of a brain tumor and lung lesions on June 30, 2000 and July 8, 2000. His reports are found at DX 8. In his consultation report dated June 30, 2000, Dr. Justice noted the miner had a history of black lung. He also noted the miner had a smoking history of 61 years. The miner complained of increased coughing and sputum production. He noted that the MRI of the brain showed two focal lesions in a metastatic pattern and that the CT scan of the thorax showed a large mass in the right perihilar area at 5.5 cm in its greatest dimensions. Dr. Justice diagnosed metastatic carcinoma, but recommended biopsy for definitive diagnosis. In his July 8, 2000 consultation report, Dr. Justice diagnosed the miner as having metastatic small cell cancer with cranial involvement and recommended that comfort measures be given.

Medical Records of Dr. Bernard Prudencio

The medical records of Dr. Prudencio appear at DX 7. Dr. Prudencio first treated the miner in October 1985, and saw him every 3 to 4 months or as needed. Throughout his records, Dr. Prudencio noted a history of pneumoconiosis. Dr. Prudencio's file contained medical reports from Dr. R. Quintana, a thoracic surgeon, who evaluated the miner for his "massive pulmonary fibrosis related to his work as a miner." Dr. Quintana had been following the miner at yearly intervals since April 1987. In a letter dated March 9, 1994, Dr. Quintana noted that the miner's massive pulmonary fibrosis was unchanged from previous years.

Medical Records of Dr. Laurence Matthews

The medical records of Dr. Matthews appear at DX 6. Dr. Matthews saw the miner on June 23, 2000, for evaluation of his current cardiovascular status. He recommended the miner reconsider his decision not have heart catheterization.

Medical Records from Cardiology Associates of Gainesville

The medical records from Cardiology Associates of Gainesville appear at DX 5. Included in the file was a pathology report of a right lung biopsy, taken on April 22, 1987. The sample was a fragment of bronchial wall tissue with a localized nodule. The diagnosis, rendered by Dr. William Hamilton, was neural tumor of bronchus. Dr. Hamilton noted this type of tumor was extremely rare.

Death Certificate

The death certificate is dated August 22, 2000, and appears at DX 4. The date of the miner's death was noted as August 20, 2000. He died in Florida. The miner was 71 years old at the time of death. The certificate of death was certified by Dr. Laurence Matthews. The immediate cause of death was listed as "natural."

Autopsy

No autopsy was performed.

Post-Mortem Reports

Dr. Richard Naeye

The medical report of Dr. Naeye is dated April 8, 2001, and appears at EX 2. Dr. Naeye is Board-Certified in Anatomical and Clinical Pathology. Dr. Naeye reviewed the miner's occupational history of 31 years of underground coal mine employment, which ended in 1980, the death certificate, and the medical records of Drs. Prudencio, Dillon, Quintana, Soong, Sargent, Matthews, and Keith. He stated that the cause of death was lung cancer that had metastasized to the brain. He noted that in October 2000, the miner had reported a smoking

history ½ pack of cigarettes per day for 60 years and continuing. Dr. Naeye also reviewed a slide containing tissue from the bronchus and a 1 mm nodule comprised of nerve sheath cells. He agreed with pathologists that this tumor was a benign neoplasm known as schwanoma. Dr. Naeye concluded, "X-ray findings of CWP were quite likely present in 1992 but some uncertainty exists because no interpretations by B-readers are available for review." Dr. Naeye stated that the miner did not have any clinical complaints that could be attributed to coal workers' pneumoconiosis and that there were no documented findings of chronic bronchitis that suggest coal workers' pneumoconiosis was causing disability. Dr. Naeye opined that the miner's death was due entirely to lung cancer and its metastases. He added that lung cancer was a well known consequence of cigarette smoking and there was no relationship between exposure to coal mine dust and subsequent lung cancer.

The supplemental report of Dr. Naeye is dated October 4, 2001, and appears at EX 2. He noted that with regard to the lung biopsy, "[T]here are no findings in this nodule or elsewhere in the tissues available for review that could be interpreted as evidence of coal workers' pneumoconiosis."

Dr. Everett Oesterling

The medical report of Dr. Oesterling is dated November 5, 2001 and appears at EX 4. Dr. Oesterling is Board-Certified in Anatomic and Clinical Pathology, and Nuclear Medicine. Dr. Oesterling reviewed the single biopsy slide and concurred it was consistent with a diagnosis of schwannoma, a benign tumor of neural origin that is totally unrelated to mine dust exposure. He referred to a chest x-ray in April 2000, that revealed extensive fibrotic lesions and a 5 x 8 cm mass in the upper lobe and a 5 x 8 mm mass in the left lung. He also noted that a lymph node biopsy showed "probable small cell carcinoma." He added that this tissue was not available for his review. Dr. Oesterling stated that small cell cancers were most typically seen in smokers. Dr. Oesterling noted, "It is unfortunate that additional tissue, specifically of the lung, is not available for histologic examination. Without such material it is not totally feasible for a pathologist to answer the questions which you posed in your letter." Nevertheless, Dr. Oesterling concluded as follows:

1. There is no lung available to establish the presence or absence of coal workers' pneumoconiosis.
2. It appears unlikely that any coalmine related disease was a factor in this gentleman's death which had resulted from metastatic small cell carcinoma complicated by cardiovascular disease due to arteriosclerosis.
3. The records do not reflect significant pulmonary or respiratory impairment, however this can not be evaluated in terms of tissue pathology.
4. It would be likely that this gentleman was disabled prior to his death by his cardiovascular disease and probably his metastatic lung tumor. These are not related to coalmine dust exposure.
5. Without lung tissue it is not possible to comment on pulmonary or respiratory impairment due to mine dust exposure.
6. With the probable causes of death it appears unlikely that mine dust exposure was in any way a factor in hastening this gentleman's death.

Dr. A. Dahhan

The medical report of Dr. Dahhan is dated January 30, 2002, and appears at EX 5. Dr. Dahhan is Board-Certified in Internal Medicine and Pulmonary Disease. Dr. Dahhan reviewed the survivor's claim for benefits; a report by the Occupational Pneumoconiosis Board; medical report of Dr. Gaziano; biopsy report of Dr. Hamilton; medical records of Drs. Dillon, Quintana, Prudencio and Justice; death certificate; x-ray interpretations by Drs. Sargent, Wheeler, Scott, and Kim; x-ray interpretation by Dr. Sung; CT Scan interpretations by Drs. Wheeler, Scott, and Kim; and the medical report of Dr. Naeye. Based on his review of the evidence, Dr. Dahhan concluded:

1. Mr. Bartley did have coal workers' pneumoconiosis.
2. Mr. Bartley had no significant functional impairment due to his coal workers' pneumoconiosis as demonstrated by the available pulmonary function studies.
3. Mr. Bartley died as a result of his brain cancer and its metastasis.
4. Mr. Bartley had a history of 60 pack years of smoking, an amount sufficient to cause the development of lung cancer in a susceptible individual.
5. Since Mr. Bartley died as a result of lung cancer, a condition not caused by, related, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis, I conclude that it would have occurred at the same time and in the same manner regardless of whether or not he had ever worked in the mining industry or was acquired coal workers' pneumoconiosis.
6. Mr. Bartley's pulmonary function studies that were obtained at the time of the diagnosis of his coal workers' pneumoconiosis showed no significant functional respiratory impairment or disability indicating that his coal workers' pneumoconiosis did not play any part, hasten or contribute to his final demise.

Deposition of Dr. Paul Wheeler[6]

The deposition testimony of Dr. Wheeler is dated May 14, 2003, and appears at EX 6. Dr. Wheeler testified with regard to his qualifications and his interpretations of the April 26, 2000 and June 28, 2000 chest x-rays, and the June 29, 2000 CT scan. Dr. Wheeler admitted he found some nodules that "conceivably could be coal workers' pneumoconiosis." However, it was his opinion that granulomatous disease was causing "probably all of the findings." He identified tuberculosis and/or histoplasmosis as the actual disease process. He opined the miner

[6] Prior to the deposition, counsel for Employer apparently gave Dr. Wheeler six (6) additional chest x-rays to review. At the deposition, counsel for Claimant objected to Dr. Wheeler's testimony regarding those findings on the basis that it violated the 20-day rule. I agree with counsel for Claimant. Any reference to Dr. Wheeler's interpretation of additional chest x-rays is stricken from the record. Specifically, I am referring to Dr. Wheeler's testimony from pages 46 through 48. (EX 6). However, even if I considered Dr. Wheeler's testimony regarding these x-rays, there would be no effect on the outcome of the case, and the findings and conclusions reached herein would remain the same.

had advanced, presumably self-healed, granulomatous disease. Dr. Wheeler noted that the TB skin test was not reliable and should not be used exclusively to rule out or rule in tuberculosis.

Dr. Wheeler stated that CT scans were the best way to detect the presence or absence of any interstitial lung disease. He felt the mass lesions, described by others as progressive massive fibrosis or complicated pneumoconiosis, were large conglomerate masses from either TB or histoplasmosis or both. Dr. Wheeler admitted that the mass lesions of conglomerate granulomatous disease and the large opacities of pneumoconiosis "can look radiologically identical." But he noted that typically when there are large opacities of silicosis, there are background nodules. In the present case, the CT scan showed no background nodules where the masses were.

Dr. Wheeler admitted that it was possible, but rare, that a person could have large opacities of coal workers' pneumoconiosis with no background nodules; he personally saw only one or two cases in his career. Dr. Wheeler noted that there were reports in American literature that large opacities of pneumoconiosis will progress, but it was his experience that they did not. Dr. Wheeler attributed the miner's COPD to smoking but admitted he did not have a smoking history from the miner when he made this determination. Dr. Wheeler added that he did not need the smoking history because of the bullous emphysema, blebs, and that the upper lobes were typical of a smoker. Dr. Wheeler noted that he did not know the miner's occupational history when reviewing the x-rays and CT scan. He noted that if the miner had been a driller working pre-World War II with no protection, he might have changed his mind regarding his findings. He added that "the odds are that these masses are…so-called conglomerate tuberculosis or histoplasmosis." Dr. Wheeler stated he was unaware that coal dust exposure caused emphysema. He also noted that COPD was caused 99.9% of the time from cigarette smoking and not from coal dust exposure. He admitted that ring calcifications have been described in silicosis and CWP. He agreed that the rings alone could not rule in or rule out CWP.

## CONCLUSIONS OF LAW

### Length of Coal Mine Employment

I find that the miner was a coal miner within the meaning of the Act for at least 28 years. (DX 2; DX 3; DX 20).

### Date of Filing

I find that Claimant filed her claim for benefits under the Act on September 28, 2000. (DX 1). This claim was timely filed.

### Responsible Operator

I find that Union Carbide Corporation is the responsible operator and will provide payment of any benefits awarded to Claimant. (DX 2; DX 3; DX 20).

## Dependents

Claimant is an eligible survivor of the miner. (see also DX 20). I find Claimant was married to the miner on April 9, 1956. (DX 23-6). The miner's death certificate indicated they were still married at the time of the miner's death. (DX 4). In her application for benefits, Claimant indicated she was the miner's surviving spouse. (DX 1). Claimant did not claim to have any other dependents for purposes of augmentation of benefits under the Act. (DX 1).

## Entitlement to Benefits

### Applicable Regulations

Claimant's claim for benefits was filed on September 28, 2000, and is governed by the Part 718 Regulations. However, on January 19, 2001, substantial changes to Parts 725 and 718 of the Federal Regulations became effective. (see footnote 1). Based upon my review of the new Regulations, there are two sections that specifically deal with the question of whether these new Regulations are applicable to cases that are currently pending at the time of the enactment.

Pursuant to § 725.2(c), the revisions of this part [Part 725] shall also apply to the adjudication of claims that were pending on January 19, 2001, except for the following sections: § 725.309, 725.310, *etc.* (S*ee* the C.F.R. for the complete list of exempted sections). Accordingly, with the exception of those sections listed as an exemption, the revisions to Part 725 will apply to the facts of this decision.

Pursuant to § 718.101(b) the standards for the administration of clinical tests and examinations contained in subpart B "shall apply to all evidence developed by any party after January 19, 2001 in connection with a claim governed by this part [718]...." (Emphasis added). Accordingly, since the evidence in the instant matter was developed prior to January 19, 2001, the newly enacted § 718, subpart B, does not apply.

On August 9, 2001, U.S. District Court Judge Emmet Sullivan upheld the validity of the new Regulations in *National Mining Association v. Chao*, No. 00-3086 (D.D.C. Aug. 9, 2001). However, on June 14, 2002, the United States Court of Appeals for the District of Columbia Circuit ("the court") affirmed in part, reversed in part, and remanded the case. *See National Mining Association v. Department of Labor*, No. 01-5278 (June 14, 2002). Accordingly, I will apply the sections of the newly revised version of Parts 718 (i.e. subparts A, C and D) and 725, which took effect on January 19, 2001, that the court did not find impermissibly retroactive to the facts of the instant matter. (see footnote 1).

### Standard of Review

The administrative law judge need not accept the opinion of any particular medical witness or expert, but must weigh all the evidence and draw his/her own conclusions and inferences. *Lafferty v. Cannelton Industries, Inc.*, 12 B.L.R. 1-190 (1989); *Stark v. Director, OWCP*, 9 B.L.R. 1-36 (1986); *Todd Shipyards Corp. v. Donovan*, 300 F.2d 741 (5th Cir. 1962).

The adjudicator's function is to resolve the conflicts in the medicalevidence; those findings will not be disturbed on appeal if supported by substantial evidence. *Lafferty, supra; Fagg v. Amax Coal Co.*, 12 B.L.R. 1-77 (1988), *aff'd*, 865 F.2d 916 (7th Cir. 1989);*Short v. Westmoreland Coal Co.*, 10 B.L.R. 1-127 (1987); *Piccin v. Director, OWCP*, 6 B.L.R. 1-616 (1983). *Peabody Coal Co. v. Lowis*, 708 F.2d 266, 5 B.L.R. 2-84 (7th Cir. 1983).

In considering the medical evidence of record, an administrative law judge must not selectively analyze the evidence. See *Wright v. Director, OWCP*, 7 B.L.R. 1-475 (1984); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Crider v. Dean Jones Coal Co.*, 6 BLR 1-606 (1983); *Peabody Coal Co. v. Lowis*, 708 F.2d 266, 5 BLR 2-84 (7th Cir. 1983); see also *Stevenson v. Windsor Power House Coal Co.*, 6 B.L.R. 1-1315 (1984). The weight of the evidence, and determinations concerning credibility of medical experts and witnesses, however, is for the administrative law judge. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986); *Brown v. Director, OWCP* , 7 B.L.R. 1-730 (1985); see also *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Henning v. Peabody Coal Co.*, 7 B.L.R. 1-753 (1985);*Peabody Coal Co. v. Benefits Review Board*, 560 F.2d 797, 1 B.L.R. 2-133 (7th Cir. 1977).

As the trier-of-fact, the administrative law judge has broad discretion to assess the evidence of record and determine whether a party has met its burden of proof. *Kuchwara v. Director, OWCP*, 7 BLR 1-167 (1984). In considering the evidence on any particular issue, the administrative law judge must be cognizant of which party bears the burden of proof. Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. *See White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Entitlement: In General

To establish entitlement to survivor's benefits, a claimant must establish that the miner had pneumoconiosis, that the miner's pneumoconiosis arose out of coal mine employment, and that the miner's death was due to pneumoconiosis. 20 C.F.R. §§ 718.3, 718.202, 718.203, 718.205(a); *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Haduck v. Director, OWCP*, 14 B.L.R. 1-29 (1990); *Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988); *Boyd v. Director, OWCP*, 11 B.L.R. 1-39 (1988). For survivor's claims filed on or after January 1, 1982, the miner's death will be considered due to pneumoconiosis if pneumoconiosis was the cause of the miner's death, was a substantially contributing cause or factor leading to the miner's death, death was caused by complications of pneumoconiosis, or if the presumption, relating to complicated pneumoconiosis, set forth at Section 718.304, is applicable. 20 C.F.R. §718.205(c)(1)-(3). Pneumoconiosis is a substantially contributing cause of death if it hastened the miner's death. 20 C.F.R. §718.205(c)(5); *Shuff v. Cedar Coal Co.*, 967 F.2d 977, 16 B.L.R. 2-90 (4th Cir. 1992), *cert. denied*, 506 U.S. 1050 (1993).

The Existence of Pneumoconiosis and the Application of Collateral Estoppel

As noted previously, the parties settled the living miner's claim in 1984 and an award of benefits was subsequently issued by the District Director. However, in the instant survivor's claim, Employer has decided to contest the issue of the existence of pneumoconiosis. This

action raises the threshold issue of whether Employer is collaterally estopped from re-litigating the existence of coal worker's pneumoconiosis in a survivor's claim where the miner was awarded benefits on a living miner's claim.[7]

For collateral estoppel to apply in the present case, which arises within the jurisdiction of the United States Court of Appeals for the Fourth Circuit, Claimant must establish that:

> (1) the issue sought to be litigated is identical to the one previously litigated;
> (2) the issue was actually determined in the prior proceeding;
> (3) the issue was a critical and necessary part of the judgment in the prior proceeding;
> (4) the prior judgment is final and valid; and
> (5) the party against whom the estoppel is asserted had a full and fair opportunity to litigate the issue in the previous forum.

*See Sedlack v. Braswell Services Group, Inc.*, 134 F.3d 219 (4th Cir. 1998); *Hughes v. Clinchfield Coal Co.*, 21 B.L.R. 1-134 (1999)(*en banc*).

At the time of the adjudication of the miner's claim, evidence sufficient to establish pneumoconiosis under one of the four methods set out at 20 C.F.R. §718.202(a)(1)-(4) obviated the need to do so under any of the other methods. *See Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985). However, subsequent to the issuance of the award of benefits in the miner's claim, the Fourth Circuit held that although Section 718.202(a) enumerates four distinct methods of establishing pneumoconiosis, all types of relevant evidence must be weighed together to determine whether a miner suffers from the disease. *See Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000); *see also Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 21 B .L.R. 2-104 (3d Cir. 1997).

In light of the change in law enunciated in *Compton*, which overruled the Board's holding in *Dixon*, the issue of whether the existence of pneumoconiosis has been established pursuant to Section 718.202(a) is not identical to the one previously litigated and actually determined in the miner's claim. *See Sedlack, supra*; *Hughes, supra*. Thus, inasmuch as each of the prerequisites for application of the doctrine of collateral estoppel is not present, I find that the doctrine of collateral estoppel is not applicable in this survivor's claim regarding the existence of pneumoconiosis pursuant to 20 C.F.R. §718.202(a). *See Surway v. United Pocahontas Coal Co*, BRB No. 01-0881 BLA (June 26, 2002)(unpub.); *Howard v. Valley Camp Coal Co.*, BRB No.

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[7] Both parties failed to raise and address the issue of collateral estoppel in their closing briefs. However the courts have generally held that the adjudicator may raise the issue of collateral estoppel *sua sponte*. In *Studio Art Theatre of Evansville, Inc. v. City of Evansville*, 76 F.3d 128, 130 (7th Cir. 1996), the circuit court held that the benefits of precluding re-litigation of issues runs not only to the litigants, but to the judicial system. Moreover, in *Doe v. Pfrommer*, 148 F.3d 73 (2d Cir. 1998), it was held that "strong public policy in economizing the use of judicial resources by avoiding re-litigation "favors *sua sponte* application of collateral estoppel." See also *Tri-Med Finance Co. v. National Century Finance Enterprises, Inc.*, 208 F.3d 215 (6th Cir. 2000).

001034 BLA (August 24, 2001)(unpub.); *Price v. Consolidated Coal Co.*, BRB No. 00-0453 BLA (January 24, 2001)(unpub.). Consequently, I will reconsider the evidence and determine whether it is sufficient to establish the existence of pneumoconiosis in accordance with the standard enunciated in *Compton.*[8]

The Existence of Pneumoconiosis

Thirty U.S.C. § 902(b) and 20 C.F.R. § 718.201 define pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." [9] The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis.[10] The term "arising out of coal mine employment" is

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[8] The instant case is distinguishable from the recent case of *Zeigler Coal Co. v. Director, OWCP [Villain]*, 312 F.3d 332 (7th Cir. 2002). In that case the Seventh Circuit held that an employer is collaterally estopped from re-litigating the existence of pneumoconiosis in a survivor's claim where the miner was awarded benefits based on a lifetime claim and no autopsy evidence is presented in the survivor's claim. In that case the claimant only had to prove the existence of pneumoconiosis within one of the discrete subsections of §718.202(a). After the underlying case in *Zeigler* was decided (on December 7, 1999), the Fourth Circuit adopted the new standard enunciated in *Compton, supra*. The Seventh Circuit has not yet ruled on this issue of weighing evidence together under §718.202(a)(1)-(4). Therefore, since there has not been any change in the law in the Seventh Circuit regarding the weighing of the evidence under this subsection, the issue in the survivor's claim was identical to the issue in the living miner's claim and collateral estoppel could be applied. Conversely, in the instant case, pursuant to the Fourth Circuit's recent holding in *Compton, supra*, the issue now presented in the survivor's claim is not identical to the issue that was presented in the living miner's claim in 1984. Therefore, since all of the prerequisites for the application of collateral estoppel are not present, the doctrine of collateral estoppel is not applicable in the instant survivor's claim regarding the existence of pneumoconiosis.

[9] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1364; *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3d Cir. 1995) at 314-315.

[10] Regulatory amendments, effective January 19, 2001, state:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis,

defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201(b).

"…[T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing, Rose v. Clinchfield Coal Co.*, 614 F. 2d 936, 938 (4th Cir. 1980). Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995).

The claimant has the burden of proving the existence of pneumoconiosis by one of four methods. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrefutable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion. 20 C.F.R. § 718.202(a). Pulmonary function studies are not diagnostic of the presence or absence of pneumoconiosis. *Burke v. Director, OWCP*, 3 B.L.R. 1-410 (1981).

As noted previously, in *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, *i.e.* x-ray evidence at § 718.202(a)(1) is

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> anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201(a) (emphasis added).

weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's decision in *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

The Existence of Complicated Pneumoconiosis

One way to prove the existence of pneumoconiosis is to show that the miner suffered from complicated pneumoconiosis. §718.202(a)(3). In fact, the major issue identified by both parties in this case is whether the miner suffered from complicated pneumoconiosis. (*See* Claimant's post-hearing brief and Employer's post-hearing brief).

Section 411(c)(3) of the Act, 30 U.S.C. §921(c)(3), and its implementing regulations found at 20 C.F.R. §§410.418 and 718.304, provide that if a miner is suffering or suffered from complicated pneumoconiosis, then there is an *irrebuttable* presumption that he is totally disabled due to pneumoconiosis, that death was due to pneumoconiosis, or that, at the time of death, he was totally disabled due to pneumoconiosis.

Complicated pneumoconiosis may be proven by x-ray evidence only if the x-ray evidence, which must be weighed, reveals one or more large opacities (greater than one centimeter in diameter), classified as category A, B, or C. 30 U.S.C. §921(c)(3)(A); 20 C.F.R. §§410.418(a), 718.304(a). Complicated pneumoconiosis may be established by autopsy or biopsy evidence, if such evidence establishes massive pulmonary lesions. 30 U.S.C. §921(c)(3)(B); 20 C.F.R. §§410.418(b), 718.304(b). Finally, a provision is made for diagnosis of complicated pneumoconiosis by other means, if the condition diagnosed would yield results similar to those described above if diagnosed by x-ray, autopsy or biopsy. 30 U.S.C. §921(c)(3)(C); 20 C.F.R. §§410.418(c), 718.304(c). The Board has construed this standard strictly in several cases. *See Lohr v. Rochester & Pittsburgh Coal Co.*, 6 B.L.R. 1-1264 (1984); *Clites v. Jones & Laughlin Steel Corp.*, 2 B.L.R. 1-1019 (1980); *Gaudiano v. United States Steel Corp.*, 1 B.L.R. 1-949 (1978).

Based on the express language of the Act as set forth at 30 U.S.C. §923(b) and *Mullins Coal Co., Inc. of Virginia v. Director, OWCP*, 484 U.S. 135, 11 B.L.R. 2-1 (1987), the Board held that Section 718.304(a)-(c) does not provide alternative means of establishing invocation of the irrebuttable presumption of total disability due to pneumoconiosis, but rather requires the administrative law judge to first evaluate the evidence in each category, and then weigh together the categories at Section 718.304(a), (b) and (c) prior to invocation. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991)(*en banc*).

Moreover, the introduction of legally sufficient evidence of complicated pneumoconiosis does not automatically qualify the claimant for the irrebuttable presumption found at Section 411(c)(3). Rather, the administrative law judge must examine all of the evidence on this issue, *i.e.*, evidence of simple and complicated pneumoconiosis, as well as evidence of no pneumoconiosis, resolve the conflicts, and make a finding of fact. *See Truitt v. North American Coal Corp.*, 2 B.L.R. 1-199 (1979), *aff'd sub nom. Director, OWCP v. North American Coal Corp.*, 626 F.2d 1137, 2 B.L.R. 2-45 (3d Cir. 1980). If the record contains any

evidence indicating the existence of complicated pneumoconiosis, the administrative law judge must specifically address it, and, if it is rejected, must provide a legitimate explanation. *Shultz v. Borgman Coal Co.*, 1 B.L.R. 1-233 (1977). The determination of whether complicated pneumoconiosis exists is finding of fact to be made by adjudicator. *Webb v. United States Pipe & Foundry Co.*, 1 B.L.R. 1-226 (1977).

Evaluation of Chest X-Ray Evidence Pursuant to §718.304(a)

The record in the instant matter contains various chest x-ray interpretations and interpretations of a CT scan taken on June 29, 2000. Although the Regulations provide no guidance for the evaluation of CT or CAT scans, Section 718.304(c) provides for new methods of diagnosis, and allows the consideration of any acceptable medical means of diagnosis. *See* 20 C.F.R. §718.304(c). Therefore, when initially weighing the evidence in each category pursuant to Section 718.204, CT scans are not to be considered x-rays, but must be evaluated pursuant to subsection (c), together with any evidence or testimony which bears on the reliability and utility of CT scans and any other evidence not applicable to subsections (a) and (b). *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991)(*en banc*).

Where two or more x-ray reports are in conflict, the radiologic qualifications of the physicians interpreting the x-rays must be considered. §718.201(a)(1).

While a judge is not required to defer to the numerical superiority of x-ray evidence, although it is within his or her discretion to do so. *Wilt v. Woverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990). The ALJ must rely on the evidence which he deems to be most probative, even where it is contrary to the numerical majority. *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1984).

In addition, the Fourth Circuit noted that pneumoconiosis is "progressive and irreversible," such that it is proper to accord greater weight to later positive x-ray studies over earlier negative studies. It stated further that generally, "later evidence is more likely to show the miner's current condition" where it is consistent in demonstrating a worsening of the miner's condition. *Lane Hollow Coal Co. v. Director, OWCP [Lockhart]*, 137 F.3d 799 (4th Cir. 1998).

The record contains twelve (12) interpretations of four (4) chest x-rays. Out of the twelve (12) interpretations, ten (10) were by dually-qualified Board-certified radiologists and B-Readers. The Board has held that it is proper to credit the interpretation of a dually qualified physician over the interpretation of a B-reader. *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (*en banc* on reconsideration). However, an administrative law judge may utilize any reasonable method of weighing such evidence. *See Sexton v. Director, OWCP*, 725 F.2d 213 (6th Cir. 1985). In general, out of these ten (10) interpretations, one (1) was read as positive for pneumoconiosis, three (3) were read as positive for pneumoconiosis *and* complicated pneumoconiosis, and six (6) were read as negative for pneumoconiosis.

With regard to the ten (10) more credible interpretations, Dr. Gale interpreted the November 30, 1981 x-ray as positive for pneumoconiosis, 1/0, p. Dr. Sargent interpreted the June 30, 1983, April 26, 2000, and the June 28, 2000 x-rays as positive for pneumoconiosis and

complicated pneumoconiosis, size C. Dr. Wheeler interpreted the April 26, 2000 and June 28, 2000 x-rays as negative for pneumoconiosis, but noted the presence of few 2 centimeter masses on the right and 2-3 centimeter masses on the left compatible w/conglomerate TB or histoplasmosis, more likely than large opacities of coal workers' pneumoconiosis because there were no background nodular infiltrates. He noted to check whether the miner was a driller with no respiratory protection.

Dr. Scott, likewise, interpreted the April 26, 2000 and the June 28, 2000 x-rays as negative for pneumoconiosis, but noted the presence of 5 x 8 centimeter masses in both upper lungs. He stated that these were "probably" granulomatous masses due to TB and that there was no background of small rounded opacities to suggest silicosis. Dr. Kim also interpreted the April 26, 2000 and June 28, 2000 x-rays as negative for pneumoconiosis but noted the presence of well-defined masses in both upper lobes, the largest measuring 8 centimeter in diameter. He added that these changes "probably" represent or were suggestive of a granulomatous process due to lack of nodules in the background.

I note that all but one of the dually qualified physicians identified the presence of large masses or opacities greater than 1 centimeter. Therefore, there is no real dispute that the miner had large masses or opacities in both lungs on chest x-ray. The difference in opinion is what agent or disease process caused the opacities or masses.

That being said, I accord less weight to the x-ray interpretations by Dr. Wheeler. First, his opinion that the masses identified in the miner's lungs were compatible with tuberculosis or histoplasmosis does not negate its compatibility with complicated pneumoconiosis. *See Keene v. G&A Coal Co.*, BRB No. 96-1689 BLA-A (September 27, 1996)(unpubl.). At his deposition, Dr. Wheeler admitted that mass lesions of conglomerate granulomatous disease and the large opacities of pneumoconiosis could look radiologically identical. He noted that "typically" when there were large opacities of silicosis, there were background nodules. Dr. Wheeler admitted that it was possible, but rare, that a person could have large opacities of pneumoconiosis with no background nodules. Dr. Wheeler stated that if the miner had been a driller working pre-World War II with no respiratory protection, he might have changed his mind regarding his findings. However, the evidence of record shows that the miner worked for approximately 28 years (from 1948 through 1980) in underground coal mines. (DX 2). He worked on a cutting machine, loading machine, and continuous miner. (DX 2). It can reasonably be assumed that the miner, especially in the earlier years, was subjected to large amounts of coal mine dust. Moreover, there is no evidence in the record that the miner ever suffered from tuberculosis or histoplasmosis, but there is ample evidence that the miner was exposed to vast amounts of coal mine dust during his 28 years of underground coal mine employment. Therefore, I find the x-ray interpretations by Dr. Wheeler unpersuasive.

Likewise, I accord less weight to the nearly identical interpretations of Drs. Scott and Kim. I find their respective opinions to be equivocal. Both noted the presence of large bilateral masses and opined these large lesions were "probably" due to or were "suggestive of" granulomatous disease. Also, I find their exclusion of complicated pneumoconiosis based on the lack of background nodules unconvincing. As Dr. Wheeler admitted, it was possible to have large opacities of pneumoconiosis with no background nodules. Moreover, there is no evidence

that Drs. Scott and Kim were aware of the miner's coal mine history. Had they each been aware that the miner had worked in underground coal mines for about 28 years starting in 1948, Drs. Scott and Kim may have changed their mind regarding the etiology of the masses noted on x-ray. For these reasons, I accord the x-ray interpretations by Drs. Scott and Kim less weight.

Conversely, I accord more weight to the x-ray interpretations by Dr. Sargent. He read the June 30, 1983, April 26, 2000, and the June 28, 2000 chest x-rays as showing large opacities, category C. I find his interpretations are consistent with the miner's occupational history and medical history. Moreover his findings of large opacities are supported by the interpretations of Drs. Wheeler, Scott, and Kim, who also noted the presence of large masses bilaterally. However, unlike Drs. Wheeler, Scott, and Kim, Dr. Sargent also identified the presence of simple pneumoconiosis. This finding is supported by the November 30, 1981 x-ray interpretation by Dr. Gale, who also noted the presence of simple pneumoconiosis. For these reasons, I accord more weight to the x-ray interpretations of Dr. Sargent.

Based on the foregoing, I find that Claimant has established the existence of complicated pneumoconiosis pursuant to §718.304(a).

Evaluation of Biopsy Evidence Pursuant to §718.304(b)

As noted previously, complicated pneumoconiosis may also be established by autopsy or biopsy evidence, if such evidence establishes massive pulmonary lesions. 30 U.S.C. §921(c)(3)(B); 20 C.F.R. §§410.418(b), 718.304(b). No autopsy was performed in this case. However, there was one biopsy of record.

A right lung biopsy of bronchial wall tissue with localized nodule was performed on April 22, 1987. (DX 5). Dr. William Hamilton prepared the pathology report. A preliminary diagnosis of neural tumor of the bronchus was made but the sample was sent out for further evaluation.

Drs. Naeye and Oesterling were sent the biopsy slide by Employer for comment. Drs. Naeye and Oesterling reviewed the single biopsy slide and concurred that the tumor was a benign neoplasm known as schwanoma. (EX 2; EX 4). Dr. Naeye noted in his supplemental report that there were no findings in the nodule or elsewhere in the tissues available for review that could be interpreted as evidence of coal workers' pneumoconiosis. (EX 2). In his report, Dr. Oesterling admitted, "It is unfortunate that additional tissue, specifically of the lung, is not available for histologic examination. Without such material it is not totally feasible for a pathologist to answer the questions which you posed in your letter." He then stated there was no lung available to establish the absence or presence of coal workers' pneumoconiosis. (EX 4).

It is clear that the single slide of lung tissue from the biopsy contained tumor cells that were later identified as a benign neoplasm known as a schwanoma. Since the objective of the biopsy was to identify a specific tumor, it is not surprising there was no evidence of coal workers' pneumoconiosis in this very small sample. As Dr. Oesterling noted, the tissue needed to make a pathologic diagnosis of coal workers' pneumoconiosis was not available. On the other hand, Dr. Naeye stated that in the nodule and "tissues" available for review, he could not find

evidence of CWP. I find Dr. Naeye's comments to be disingenuous. Dr. Naeye never commented on the quality of the sample or whether it was appropriate or adequate for making a diagnosis of pneumoconiosis. It is not surprising that he could not find evidence of coal workers' pneumoconiosis in a tissue sample primarily containing a benign neoplasm and nerve cells. For these reasons, I accord the opinion of Dr. Naeye little weight on this issue and find that the biopsy sample was inadequate to determine the absence or presence of pneumoconiosis.

Accordingly, Claimant has failed to establish the presence of complicated pneumoconiosis pursuant to §718.304(b).

Evaluation of Other Relevant Evidence Pursuant to §718.304(c)

Finally, a provision is made for diagnosis of complicated pneumoconiosis by other means, if the condition diagnosed would yield results similar to those described above if diagnosed by x-ray, autopsy or biopsy. 30 U.S.C. §921(c)(3)(C); 20 C.F.R. §§410.418(c), 718.304(c).

The record contains various interpretations of a CT scan taken on June 29, 2000. The CT scan was read by Drs. Wheeler, Scott, and Kim as negative for pneumoconiosis. The CT scan interpretations by Drs. Wheeler, Scott, and Kim were virtually identical to their x-ray interpretations. Dr. Wheeler in his deposition stated that CT scans were the best way to detect the presence or absence of any interstitial disease. However, the Seventh Circuit, in *Consolidation Coal Co. v. Director, OWCP [Stein]*, 294 F. 3d 885 (7th Cir. 2002), pointed out that the Department has rejected the view that a CT scan, by itself, "is sufficiently reliable that a negative result effectively rules out the existence of pneumoconiosis." 65 Fed. Reg. 79, 920, 79, 945 (Dec. 20, 2000). Moreover, as Dr. Wheeler admitted at his deposition, it was possible for a person to have large opacities of pneumoconiosis without background nodules. So even if the CT scan showed no background nodules, as Drs. Wheeler, Scott, and Kim claim, this fact alone does not rule out complicated pneumoconiosis as a possible diagnosis. Once again, Dr. Wheeler's opinion that the masses identified in the miner's lungs were compatible with tuberculosis or histoplasmosis does not negate its compatibility with complicated pneumoconiosis. In addition, I find the interpretations of Drs. Scott and Kim are equivocal as they note "probably granulomatous masses" or "probable granulomatous process." For these reasons, I accord less weight overall to the CT scan evidence as it relates to the diagnosis of complicated pneumoconiosis.

Also of record are various medical reports and medical records relating to a diagnosis of complicated pneumoconiosis. Dr. Gaziano conducted an examination of the miner at the request of the Department of Labor in his living miner claim. Dr. Gaziano diagnosed the miner with complicated pneumoconiosis presumably based on his own B-reading of the June 30, 1983 chest x-ray. (DX 23-8). I find the opinion of Dr. Gaziano to be well-reasoned and well-documented and consistent with the chest x-ray evidence, the miner's occupational history of 28 years of underground coal mine employment, physical examination, subjective complaints, and medical history.

In addition there are various treatment records from the miner's physicians in the record. The miner's cardiologist, Dr. Dillon noted the miner's major problem was related to CWP and that his chest x-ray showed significant scarring and plaquing presumably related to his coal mine work. (DX 9). Dr. Quintana, a thoracic surgeon, evaluated the miner annually for his "massive pulmonary fibrosis related to his work as a miner." (DX 7). I find that the opinions of these treating physicians further support a diagnosis of complicated pneumoconiosis. Moreover, I note that there was not one mention by any of the treating physicians of a diagnosis of tuberculosis or histoplasmosis, nor was there a positive TB test.

On the other hand, there are the medical reports of Drs. Naeye, Oesterling, and Dahhan. Although Dr. Naeye is a highly qualified pathologist, I accord his opinion less weight. Dr. Naeye did not render an opinion whether complicated pneumoconiosis was present; he did state that x-ray findings of CWP were "quite likely" present in 1992, but was unsure because there were no interpretations by B-readers available for review. However, at the beginning of his report Dr. Naeye noted he reviewed the medical records of Dr. Sargent who is a Board-Certified Radiologist and B-reader. As I noted previously, Dr. Sargent, on three separate occasions, interpreted x-rays as positive for complicated pneumoconiosis. In addition, Dr. Naeye stated the miner had no clinical complaints that could be attributed to pneumoconiosis. Once again, I note that Dr. Naeye purportedly reviewed the records of Drs. Prudencio, Dillon, and Quintana before rendering an opinion in this matter. Their records show that the miner complained of coughing episodes and shortness of breath. (DX 9). Based on the foregoing, I find the opinion of Dr. Naeye is not well-reasoned and is not well-documented, and is thereby accorded less weight.

Likewise, I accord less weight to the highly qualified opinion of Dr. Oesterling. Other than the single biopsy slide that he reviewed, it is unknown what information Dr. Oesterling reviewed in making his conclusions. Moreover, Dr. Oesterling admitted in his report that without additional tissue samples to evaluate, it was not totally feasible for a pathologist to answer the questions posed by Employer. Nevertheless, Dr. Oesterling rendered a serious of opinions couched in vague terms such as "unlikely" or "likely." He noted that the "records" did not reflect significant pulmonary impairment but as I noted it is unknown what records Dr. Oesterling had in his possession in making his conclusions. For these reasons, I find the opinion of Dr. Oesterling is not well-reasoned and is not well-documented and is thereby accorded less weight.

I also accord less weight to the highly qualified opinion of Dr. Dahhan. After reviewing the evidence of record, Dr. Dahhan concluded, without explanation, that the miner had coal workers' pneumoconiosis. He offered no opinion as to whether the miner suffered from complicated pneumoconiosis and he did not provide any explanation how he evaluated the conflicting x-rays and CT scan interpretations or how they factored into his conclusions. He also noted that the miner had no functional impairment due to pneumoconiosis due to the available vent studies. However, the only vent study in the record was from 1983. I find that it is not reasonable to render an opinion on the miner's pulmonary function at the time of death based on a pulmonary function study conducted 17 years before the miner's death. For these reasons, I find the opinion of Dr. Dahhan is not well-reasoned and is not well-documented and thereby is accorded less weight.

Based on the foregoing, I find that Claimant has established complicated pneumoconiosis pursuant to §718.304(c).

Weigh all Evidence Together[11]

As noted previously, Section 718.304(a) (c) does not provide alternative means of establishing invocation of the irrebuttable presumption of total disability due to pneumoconiosis, but rather requires the administrative law judge to first evaluate the evidence in each category, and then weigh together the categories at Section 718.304(a), (b) and (c) prior to invocation. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991)(en banc).

Accordingly, I must weigh all of the evidence relating to the existence of complicated pneumoconiosis together. After weighing all of the above evidence, I find that Claimant has established the existence of complicated pneumoconiosis pursuant to §718.304. In arriving at this conclusion, I once again accord greater weight to the more credible x-ray interpretations of Dr. Sargent, the well-reasoned and well-documented medical report of Dr. Gaziano, as well as the treatment records of the miner's various physicians.

Death Due to Pneumoconiosis

The remaining issue is whether the miner's death was due to pneumoconiosis. Subsection 718.205(c) applies to survivor's claims filed on or after January 1, 1982 and provides that death will be due to pneumoconiosis if any of the following criteria are met:

(1) competent medical evidence established that the miner's death was due to pneumoconiosis; or
(2) pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis; or
(3) the presumption of §718.304 [complicated pneumoconiosis] is applicable.

20 C.F.R. §718.205(c). Pursuant to §718.205(c)(5), pneumoconiosis is a substantially contributing case of a miner's death if it hastens the miner's death.

As noted, Claimant has established the existence of complicated pneumoconiosis pursuant to §718.304 and is thereby entitled to the irrebuttable presumption that the miner's death was due to pneumoconiosis.

[11] Pursuant to *Compton, supra* all relevant evidence regarding the existence of pneumoconiosis must be weighed together under §718.202(a). I have discussed in detail all of the relevant evidence of record in my analysis under §718.304. Accordingly, I find that in weighing all of the evidence, Claimant has established the existence of pneumoconiosis pursuant to §718.202(a). Again, I accord greater weight to the x-ray interpretations of Dr. Sargent, the opinion of Dr. Gaziano, and the treatment records of the miner's physicians.

Date of Entitlement to Benefits

Since the miner died on August 20, 2000, Claimant is entitled to receive augmented benefits, as his surviving spouse, commencing as of August 1, 2000. 20 C.F.R. §725.212 and §725.213(a).

Attorney's Fees

No award of attorney's fees for services to the Claimant is made herein since no application has been received. Thirty days are hereby allowed to Claimant's counsel for the submission of such application. Counsels' attention is directed to 20 C.F.R. §§725.365 and 725.366 of the Regulations. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. Parties have ten days following receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

**ORDER**

The claim of CATHERINE D. BARTLEY, as surviving spouse of ARNOLD BARTLEY, for benefits under the Black Lung Benefits Act is hereby GRANTED.

It is hereby ORDERED that UNION CARBIDE CORPORATION, the Responsible Operator, shall pay to the Claimant, CATHERINE D. BARTLEY, all augmented benefits to which she is entitled under the Act, commencing as of August 1, 2000.

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ROBERT J. LESNICK
Administrative Law Judge

RJL/LW/dmr

**Notice of Appeal Rights**: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing a Notice of Appeals with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Room N-2117, Frances Perkins Building, 200 Constitution Avenue, N.W., Washington, D.C. 20210.